

STATE OF ILLINOIS

Page 2

Facility Name & ID Number GRANGE NURSING HOME# 0014399 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>55</u>	TOTALS	<u>55</u>	<u>20,075</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>359</u>		<u>289</u>	<u>648</u>	8
9	SNF/PED					9
10	ICF	<u>8,007</u>	<u>9,738</u>		<u>17,745</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,366</u>	<u>9,738</u>	<u>289</u>	<u>18,393</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.62%

D. How many bed-hold days during this year were paid by Public Aid?

81 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/07/64

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 9 and days of care provided 289Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

GRANGE NURSING HOME

0014399

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	90,790	2,130	5,522	98,442		98,442		98,442		1
2	Food Purchase		57,756		57,756		57,756		57,756		2
3	Housekeeping	68,220	5,073		73,293		73,293		73,293		3
4	Laundry	33,675	5,815		39,490		39,490		39,490		4
5	Heat and Other Utilities			45,709	45,709		45,709		45,709		5
6	Maintenance	24,198	8,989	23,021	56,208		56,208	587	56,795		6
7	Other (specify):*										7
8	TOTAL General Services	216,883	79,763	74,252	370,898		370,898	587	371,485		8
	B. Health Care and Programs										
9	Medical Director			1,275	1,275		1,275		1,275		9
10	Nursing and Medical Records	597,399	9,559	161,646	768,604		768,604		768,604		10
10a	Therapy	20,308		4,486	24,794		24,794		24,794		10a
11	Activities	29,607	983	1,260	31,850		31,850		31,850		11
12	Social Services	23,065		1,260	24,325		24,325		24,325		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	670,379	10,542	169,927	850,848		850,848		850,848		16
	C. General Administration										
17	Administrative	37,297			37,297		37,297		37,297		17
18	Directors Fees										18
19	Professional Services			98,464	98,464		98,464		98,464		19
20	Dues, Fees, Subscriptions & Promotions			5,921	5,921		5,921	(497)	5,424		20
21	Clerical & General Office Expenses	28,114	6,554	5,066	39,734		39,734	(25)	39,709		21
22	Employee Benefits & Payroll Taxes			123,785	123,785		123,785		123,785		22
23	Inservice Training & Education			325	325		325		325		23
24	Travel and Seminar			3,217	3,217		3,217		3,217		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			25,561	25,561		25,561		25,561		26
27	Other (specify):*										27
28	TOTAL General Administration	65,411	6,554	262,339	334,304		334,304	(522)	333,782		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	952,673	96,859	506,518	1,556,050		1,556,050	65	1,556,115		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **GRANGE NURSING HOME**

#0014399

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			43,336	43,336		43,336		43,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,759	1,759		1,759		1,759			35
36	Other (specify):*											36
37	TOTAL Ownership			45,095	45,095		45,095		45,095			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,200	26,969	46,169		46,169		46,169			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,113	30,113		30,113		30,113			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		19,200	57,082	76,282		76,282		76,282			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	952,673	116,059	608,695	1,677,427		1,677,427	65	1,677,492			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number GRANGE NURSING HOME

0014399

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(226)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(271)	20		28
29	Other-Attach Schedule	587			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 65		\$	30

OHF USE ONLY							
48		49	50	51	52		

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 65		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

GRANGE NURSING HOME

ID# 0014399

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	SUMMARY OF LINE 29 OTHER ELIM	\$	1
2	DEFERRED MAINT PAINTING PER SCHXIX-H	587	6
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	587	49

Summary A

0014399

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

12/31/2002

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	BOARD MEMBERS								\$	1
2	CHARLOTTE MEHRTENS	PRESIDENT	BOARD MEMBER							2
3	BARBARA JOSEPH	SEC/TREAS	BOARD MEMBER							3
4	HENRIETTA KELLER	VICE PRESIDENT	BOARD MEMBER							4
5	STANLEY PANNIER		BOARD MEMBER							5
6	JIM ECKERT		BOARD MEMBER							6
7	DON SCHAEFFER		BOARD MEMBER							7
8										8
9										9
10	THE BOARD OF DIRECTORS DO NOT PROVIDE DIRECT SERVICE TO THE FACILITY OR RECEIVED COMPENSATION.									10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NOT APPLICABLE						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

B Real Estate Taxes		<div style="border: 1px solid black; padding: 2px; color: red; font-weight: bold;"> <i>Important</i>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1.	Real Estate Tax accrual used on 2001 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <div style="color: red; font-weight: bold;">(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</div>	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <div style="display: flex; justify-content: space-between; align-items: center;"> TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.) </div>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1997		8
	1998		9
	1999		10
	2000		11
	2001		12

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION \$			16

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GRANGE NURSING HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0014399

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,712

B. General Construction Type: Exterior BRICK Frame

Number of Stories 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	CARE FACILITY	30,000	1962	\$ 1,064	1
2					2
3	TOTALS	30,000		\$ 1,064	3

Facility Name & ID Number GRANGE NURSING HOME

0014399

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1963	1963	\$ 125,662	\$ 2,513	50	\$ 2,513		\$ 99,414	4
5	26		1969	1969	148,564	3,714	40	3,714		122,256	5
6											6
7											7
8											8
	Improvement Type**										
9		SEWER AND WATER		1964	7,560	151	50	151		5,871	9
10		SPRINKLER		1975	27,550		20			27,550	10
11		SPRINKLER		1977	840		20			840	11
12		SMOKE DETECTOR		1976	6,485		10			6,485	12
13		SOLARIUM		1979	26,719	1,089	15	1,089		24,136	13
14		SOLARIUM IMPROVEMENTS		1983	500		25			500	14
15		SEAMLESS FLOOR		1982	2,008		7			2,008	15
16		HEATING AND COLLING		1985	36,010	1,801	20	1,801		31,518	16
17		NEW ROOF		1985	24,000		15			24,000	17
18		INSULATION		1985	3,980		15			3,980	18
19		SPRINKLER		1985	2,187	109	20	109		1,948	19
20		BUILDING ADDITION		1987	272,812	10,104	27	10,104		155,936	20
21		SKYLIGHTS		1988	1,790	90	20	90		1,317	21
22		WINDOWS		1988	1,138	57	20	57		798	22
23		BATHROOM REMODELING		1989	10,065	503	20	503		6,877	23
24		CHAIR RAILS		1989	441		10	152	152	441	24
25		SHUTOFF VALVES		1990	3,045	152	20	458	306	1,940	25
26		DOOR ALARM AND AIR CONDITIONERS		1990	2,425		10	147	147	2,425	26
27		HEAT PUMP AND AWNING		1993	4,577	458	10	63	(395)	4,402	27
28		FENCE		1993	2,931	147	20	668	521	1,347	28
29		SPRINKLERS, KEYPAD TO PATIO DOORS		1994	1,267	63	20	535	472	544	29
30		SIDEWALKS, TREES		1994	13,361	668	20	620	(48)	5,624	30
31		ACTIVITY DOORS, CODE ALERT, DOOR ALARM		1994	5,346	535	10	487	(48)	4,377	31
32		AWNING, EXHAUST FANS		1994	6,204	620	10	450	(170)	5,013	32
33		COURTYARD		1996	7,310	487	15	129	(358)	3,166	33
34		SOILED UTILITY ROOM		1996	6,751	450	15	311	(139)	2,925	34
35		30% DOWNPAYMENT ON FIRE ALARM SYSTEM		1997	2,573	129	20		(129)	838	35
36		BALANCE OF FIRE ALARM SYSTEM		1997	6,226	311	20			1,711	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number GRANGE NURSING HOME

0014399

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	HOT WATER HEATER AND INSTALLATION	1997	\$ 3,476	\$ 348	10	\$ 348	\$	\$ 1,914	37
38	NEW SPRINKLER AND INSTALLATION	1997	4,618	185	25	185		1,017	38
39	ELECTRICAL WORKLIGHTS IN GARDEN AREA	1997	1,402	70	20	70		385	39
40	Labor/materials to install water repellant wallcovering &	1997	2,112	141	15	141		775	40
41	regROUT the existing tile in north hall shower								41
42	Labor/materials to gut the existing nurses station (to be	1997	10,764	718	15	718		3,949	42
43	completed in 1998). Labor/materials to remove and rebuild								43
44	walls to create 2 new office areas, install carpet, paint, and								44
45	install window in new office areas.								45
46	HOT WATER BOILER	1997	2,800	140	20	140		770	46
47	CARPET FOR WALLS THROUGHOUT THE FACILITY	1997	1,488	99	15	99		545	47
48	Labor/materials to complete the installation of new phone	1998	10,151	1,015	10	1,015		4,568	48
49	linew, lighting, cabinetry, countertops, and wallcovering								49
50	in nurses station. Applied protective panels to door facings								50
51	and wallcoverings down hallways.								51
52	RETUBING BOILER	1998	2,530	253	10	253		1,139	52
53	INSTALL ANNUNCIATOR PANEL	1998	402	21	19	21		105	53
54	INSTALL AIR HANDLER	1999	2,900	145	20	145		508	54
55	Labor/materials to hang wallcovering, paint, and patch the	1999	2,628	263	10	263		920	55
56	ceiling in the dining room.								56
57	TOP DRESS ROCK AREAS OF PARKING LOT WITH ROCK	2001	1,900	380	5	380		570	57
58	Totally demolish and rebuild 2 distinct bathrooms.	2001	26,134	2,613	10	2,613		3,920	58
59	INSTALL AIR COMPRESSOR FOR SPRINKLER SYSTEM	2002	1,519	76	10	76		76	59
60	Relocate 3 radiant heat lines and replace concrete floor	2002	4,674	234	10	234		234	60
61	in laundry								61
62	Replace lights, repair water heater, replace fans, install new	2002	2,749	137	10	137		137	62
63	valves and faucets, replace drain connections, replace sinks								63
64	in individual baths on north hall								64
65	Demolish existing baths on south hall and prepare for	2002	14,902	745	10	745		745	65
66	renovations. Sand and mudd for drywall patch work,								66
67	reinstall call light and light fixture, realign tub and shower,								67
68	relocate existing toilet, install new toilet, remove existing								68
69	wall, tile and receptacle boxes, paint ceiling and walls,								69
70	TOTAL (lines 4 thru 69)		\$ 857,476	\$ 31,734		\$ 31,734	\$ 311	\$ 572,464	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 857,476	\$ 31,734		\$ 31,734	\$	\$ 572,464	1
2	Renovations of south hall baths continued:								2
3	break up and replace concrete floor to relocate main								3
4	for existing water closet and add drain for new H.C. type								4
5	water closet, repipe water lines for tub, relocate tub in								5
6	recessed wall, relocate piping for bed pan washer,								6
7	replaced plumbing and new floor tile, hang cubicle track								7
8	and curtain, frame and drywall new wall, install handrail								8
9	Repair kitchen area drains and grease trap, construct dust	2002	11,009	550	10	550		550	9
10	wall, break up concrete in dining area, remove concrete								10
11	stoop, repipe U.G. piping from hand sink and ice maker wall								11
12	install 250 gallon concrete grease trap, extend new sewer								12
13	to south sewer line and tie in, replace concrete								13
14	Gutted and redesigned existing bookkeeper's office, installed	2002	2,160	108	10	108		108	14
15	new flooring, walls, and ceiling, installed new cabinetry								15
16	and workspace								16
17	Gutted existing solarium, installed new flooring, walls, and	2002	8,342	417	10	417		417	17
18	ceiling, replaced windows.								18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 878,987	\$ 32,809		\$ 32,809	\$	\$ 573,539	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 89,149	\$ 10,035	\$ 10,035	\$	Variable	\$ 55,664	71
72	Current Year Purchases	8,043	492	492		Variable	492	72
73	Fully Depreciated Assets	198,483				Variable	198,483	73
74								74
75	TOTALS	\$ 295,675	\$ 10,527	\$ 10,527	\$		\$ 254,639	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,175,726	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,336	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,336	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 828,178	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,759 Description: DISH MACHINE (1739), RUG CLEANER (20)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

WE ONLY HIRE TRAINED AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3;39/2	hrs	\$	93	\$ 6,956	\$ 135	93	\$ 7,091	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		50	4,114		50	4,114	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		207	14,392		207	14,392	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				9,478		9,478	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	tubefeeding, medical supply, oxygen	39/2								
13	Other (specify): lab, xray	39/3				1,507	9,587		11,094	13
14	TOTAL			\$	350	\$ 26,969	\$ 19,200	350	\$ 46,169	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	184,156		3
4	Supply Inventory (priced at cost)	11,058		4
5	Short-Term Investments	470,558		5
6	Prepaid Insurance	7,732		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 699,654	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,064		13
14	Buildings, at Historical Cost	879,812		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	294,850		16
17	Accumulated Depreciation (book methods)	(828,177)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 347,549	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,047,203	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,543	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,099		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,943		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 85,585	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 85,585	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 961,618	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,047,203	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,056,255	1
2	Restatements (describe):		2
3	To correct prior year accounts receivable	(1,356)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,054,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,281)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (93,281)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 961,618	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,516,690	1
2	Discounts and Allowances for all Levels	11,030	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,527,720	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	45,340	6
7	Oxygen	92	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 45,432	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,829	19
20	Radiology and X-Ray	1,575	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,404	23
D. Non-Operating Revenue			
24	Contributions	630	24
25	Interest and Other Investment Income***	6,960	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,590	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,584,146	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	370,898	31
32	Health Care	850,848	32
33	General Administration	334,304	33
B. Capital Expense			
34	Ownership	45,095	34
C. Ancillary Expense			
35	Special Cost Centers	46,169	35
36	Provider Participation Fee	30,113	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,677,427	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,281)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,281)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number GRANGE NURSING HOME# 0014399Report Period Beginning: 01/01/2002Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	1,920	\$ 38,788	\$ 20.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,418	1,542	25,624	16.62	3
4	Licensed Practical Nurses	13,111	14,133	207,918	14.71	4
5	Nurse Aides & Orderlies	31,391	35,317	325,069	9.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,777	2,014	20,308	10.08	8
9	Activity Director	2,669	2,887	29,607	10.26	9
10	Activity Assistants					10
11	Social Service Workers	1,727	2,001	23,065	11.53	11
12	Dietician					12
13	Food Service Supervisor	1,680	1,874	16,715	8.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,566	9,986	74,075	7.42	15
16	Dishwashers					16
17	Maintenance Workers	1,881	2,097	24,198	11.54	17
18	Housekeepers	6,256	6,727	68,220	10.14	18
19	Laundry	3,633	4,046	33,675	8.32	19
20	Administrator	1,928	2,080	37,297	17.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,956	2,176	28,114	12.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	80,873	88,800	\$ 952,673 *	\$ 10.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	118	\$ 5,522	1/3	35
36	Medical Director		1,275	9/3	36
37	Medical Records Consultant	13	397	10/3	37
38	Nurse Consultant	11	381	10/3	38
39	Pharmacist Consultant		600	10/3	39
40	Physical Therapy Consultant	75	4,313	10A/3	40
41	Occupational Therapy Consultant	3	173	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,260	11/3	44
45	Social Service Consultant		1,260	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		810	19/3	47
48	BILLING CONSULTANT		1,443	19/3	48
49	TOTAL (lines 35 - 48)	220	\$ 17,434		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	43	\$ 1,187	10/3	50
51	Licensed Practical Nurses	1,804	51,338	10/3	51
52	Nurse Aides	5,982	107,743	10/3	52
53	TOTAL (lines 50 - 52)	7,829	\$ 160,268		53

Facility Name & ID Number **GRANGE NURSING HOME**# **0014399**Report Period Beginning: **01/01/2002**Ending: **12/31/2002****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description		Description		Description			
SHEILA STOREY	ADMINISTRATOR	0	\$ 37,297	Workers' Compensation Insurance	\$ 29,299	IDPH License Fee	\$				
				Unemployment Compensation Insurance	6,865	Advertising: Employee Recruitment		2,142			
				FICA Taxes	72,879	Health Care Worker Background Check		542			
				Employee Health Insurance	6,627	(Indicate # of checks performed 45)					
				Employee Meals	1,775	PUBLIC RELATIONS & DIR ADV (ELIM)		497			
				Illinois Municipal Retirement Fund (IMRF)*		NAGNA (2230) INHAA (150)		2,380			
				VACCINES	1,380	SUBSCRIPTIONS		100			
				PARTIES, FOOD, MISC	4,960	SAM'S (30) CORP FEES (10)		40			
						DON (70)CLIA (150)		220			
						Less: Public Relations Expense		(226)			
						Non-allowable advertising	(
						Yellow page advertising		(271)			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 37,297			TOTAL (agree to Sch. V,	\$	5,424			
(List each licensed administrator separately.)						line 20, col. 8)					
B. Administrative - Other				TOTAL (agree to Schedule V,	\$ 123,785						
				line 22, col.8)							
Description			Amount	E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**					
			\$	to Owners or Employees							
						Description		Amount			
				Description	Line #						
						Out-of-State Travel	\$				
						In-State Travel		560			
						Seminar Expense		2,657			
						Entertainment Expense	(
						(agree to Sch. V,					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL	\$	line 24, col. 8)	\$	3,217			
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount								
JAMESTOWN MANAGEMENT	MANAGEMENT		\$ 94,600								
M.E.S	PURCHASING CONS		810								
MIKRON	COMPUTER		1,260								
RICHARD BRESLIN	ACCOUNTANT		295								
NCS HEALTHCARE	BILLING CONS		1,443								
ST. CLAIR COUNTY COURTHOU	RECORDING AGENT		56								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 98,464								
(If total legal fees exceed \$2500 attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING	2001	\$ 1,762	3	\$	\$	\$ 294	\$ 587	\$ 587	\$ 294	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,762		\$	\$	\$ 294	\$ 587	\$ 587	\$ 294	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,113
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,775 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.